



Mental Health and Disability Services Redesign

Outcomes and Performance Measures Committee Meeting

Monday, October 15, 2012

10:00 am – 3:00 pm

Location: Polk County River Place

MINUTES

Attendance: Bob Bacon, Diane Diamond, Sen. Joni Ernst, Rep. Joel Fry, Becky Harker, Chris Hoffman, Mike Johannsen, Todd Lange, Geoffrey Lauer, Liz Matney, Mike Peterson, Rick Shults, Dr. Carolyn Turvey, David VanNingen

Facilitator: Rick Shults

DHS Staff: Lauren Erickson, Lin Nibbelink

Other Attendees:

Jess Benson	Legislative Services Agency
Deb Brodersen	Spencer Hospital
Becky Hedges	Easter Seals
Sara Lupkes	Polk County Health Services
Kelley Pennington	Magellan
Cayla Price	Pathways Intern

UPDATE FROM SERVICE SYSTEM DATA AND STATISTICAL INFORMATION INTEGRATION WORKGROUP

- There is a consensus on key principles: won't require a single transaction system. Each entity (provider, region, county, others) can have its own system such as billings, electronic health records, MMIS, etc. The workgroup will gather information from all of those. Today most counties use CSN system.
- However, all the systems need to be able to submit standardized information to measure outcomes and performance measures. Warehouse approach: information comes into the data system and is appropriately available to multiple users.
- Need to keep our eye out to improve and minimize the cost of data gathering and transaction systems. Some providers may have sophisticated systems, others such as HCBS providers, may want to come together to build an information exchange system.
- As much as possible, outcomes and performance measures will be pulled from the information that is already gathered in the normal course of business.

- “Unique identifiers” was an extensive discussion in the data group. It is currently difficult to match up data between systems. If we modernize the use of unique identifiers, it could minimize data collection, while still maintaining confidentiality requirements.
- Did anyone discuss the Department of Education identifier and if it can be used longitudinally? They have their own set of confidentiality issues that can be overcome (by warehousing and de-identifying it).
- We also have the Health Information Exchange (HIE) issue coming up. Department of Corrections has their own database. Any talk of common platform? Excellent point. How do we position ourselves so that we are complementary and take advantage of the progress being made in health information exchange? Though the focus of HIE is not behavioral health.
- The principle is for data to be useful to many stakeholders. Would access to a data warehouse be episodic or real time?
- Data would be exchanged a minimum of monthly. Not real time but much more current than we have now. That should encourage people to comply.
- We’re exploring to what degree the information can be appropriately shared. There will be various levels of security.

REVIEW OVERALL PURPOSE OF OUTCOMES AND PERFORMANCE MEASURES

Define what success means for this committee

- This will lay the path forward for the work to follow. Think about the report and recommendations as a way to give instructions to those who have to do the work afterwards. We need a balance between sending instructions versus building the whole thing.
- It’s unlikely we’ll come up with a final version of what a survey will look like. However, some people are saying “this is very important and needs to be included,” so those messages need to get through as well.
- As the governing board with a management function, we will provide some broad parameters of what the outcomes are, and then somebody does the committee work.
- Looking back a few things come to mind:
 - The efforts to survey have a degree of validity and reliability but there are experts who do that.
 - Family and natural supports and person centeredness for the most part are not currently collected in Iowa, especially given that these are essential to people living in their homes.
 - I recommend mandating that the regional system includes measures to address domains beyond just mental health and developmental disabilities (i.e., substance abuse, brain injury and multi-occurring).
- Here a few additional observations:
 - We need a consistent set of clear and understandable expectations over time using the experts, so we can, as a business, participate.
 - We and the state use those expectations to look at quality improvement over time.
 - The Director and/or Commission are also able to use these to hold a region accountable.

- We need a communication outreach strategy for everything/everyone, to say “we’ve redesigned the system” to all taxpayers, and “this is how it’s going to work”. We also need training for the people who will gather the data, especially if interview skills will be needed.
- Success needs to reflect the value of partnership, so the system reflects the values.
- We’ve decided we’ll gather information directly from people served, and other information from other people who know them (providers and others).
- Quality improvement – we want to be able to see how well we’re doing in various places across the state. What else?
- We need some kind of public report on an annual basis, including actual regional scores just like how we track data trends. Also need recommendations for the community of lowans like we report on colleges by regions.
- Accountability for the funding should be included in the reports.
- We should be able to explain to a layperson how/why their taxpayer money is being used and if we don’t do it this way how much more it’ll cost them.
- We should utilize cutting edge dashboard technology, with graphs and charts but not too many, so we engage the public.
- Keep it useful. Don’t make people be defensive and competitive. Include a narrative about trends and how to explain variances.
- Legislators want to know how well the system is working so it can be improved. Look at IDPH’s workforce group. Ongoing need to build capacity in terms of best practices. When we have data and are able to compare across regions maybe we’ll have shared ownership for making the system better.
- Might be better if done in partnership with a cross section stakeholder group and not one entity (have the report come from them, not from DHS).
- What resources are needed to do the assessments?
- We need an executive summary so people actually read it.
- There needs to be a budget (costs) with it.
- Who actually does these interviews? Could it actually be case managers? Who does it in other states? Some states train consumers. It will take time and money and serious effort by a lot.
- A lot of states do use case managers and/or peer support specialists to conduct interviews; although you have to be careful about conflict of interest.
- It is hard for the ID population to make a change because they see their case worker as their friend. Our daughter is an expert in figuring out how to case manage her own care.

WORKGROUP DISCUSSION ON REPORT AND RECOMMENDATIONS

- We need to discuss preliminary and crude estimates re: impact of decisions we’ve made and the size of the survey we need to have.
- If we were to look at surveying all people in different disability populations in one pool for the whole state, we’d have to have 400 completed valid surveys based on numbers served in 2011.

- We don't know what the regions are going to do. [But we drew up 17 hypothetical regions for this exercise](#), and sent it through a random calculator. In this case we would need 4,783 completed surveys.
- We have one region with 18 counties already, and one with four counties. Services are still delivered locally as before redesign. To the extent that regionalization improves capacity, you might even have a larger population to serve.
- If consumers are divided across 17 hypothetical regions and by population group (MI, ID, BI, DD) then 11,602 people would need to be surveyed.
- What if we start with the 400 and scale up over time as needed? Then you can't compare region to region and that's required.
- Do we need equal representation from each group, or proportional?
- A region may be doing better for one group than another.
- The law says we need to be able to drill down. We need to be able to compare multi-occurring disorders, including substance abuse, and regions.
- What if you use the trending data (4,800) to tell you if you need to do the full 11,000?
- If we take a population sample at 95 percent confidence level over three (3) years, the total number is around 1,800 for the HCBS waiver.
- It would be nice to get a really good snapshot for the first assessment of all those groups and regions, and then do three-year cycles after that. If you have the resources for it.
- We could go back to legislature and say here is what it will cost to get what we want. If we want to really see what consumers are getting we have to get to the 11,000 level.
- Regarding cost, some can be Medicaid administrative costs.
- It concerns me that the regions could be evaluated on a performance based contract without any consumer input. We need to at least acknowledge this in the report. That the letter of the law could be met, but not the spirit of the law.
- People understand what's being measured and meaningful in their lives.
- Part of the success is that the performance based contract will include consumer involvement.
- What I am hearing is that the whole state sample size might be helpful to us in a test environment, to help build the instrument itself; mid-size to include the consumer and family voice in effectiveness and efficiency of service delivery. This would be a minimum for region by region. Should have as a goal to gather this for all populations (11,000) and identify the additional resources needed.
- And results of all of this discussion are subject to expert advice.
- We had conversations with some experts; the idea was maybe the size of region affects the sample size.
- Same proportion of people served. So, oversample the smaller regions.
- We have some experts at CMS and CDD. Subdividing the survey into sections complicates this even more.
- Moving this forward is dependent on resources.

DISCUSSION OVER CONSUMER AND FAMILY SURVEY PROCESS

- Which consumer populations will be surveyed?
- Random selection of all the people with ID, DD, BI who get services. Do we do it for everyone who receives publicly funded mental health services or do we try to narrow that group down? There's a group who go to a MHC with acute symptoms, not severe or lengthy, they get stabilized, they move on versus people with serious and persistent mental illness (SPMI).
- Federal government often narrows it to people with SPMI. What are the desires of this group?
- Include those receiving or who have received subacute crisis services.
- What about services accessed by families and children?
- With limited resources, I'd like each survey to be very informative, so we would want to oversample people with SPMI.
- The CHI surveys everyone each six months.
- In a rural area if we only survey the SPMI that won't capture a lot of what happens, so I'd be concerned about limiting it.
- Measure "access" domain of everyone; measure all the other domains of SPMI only.

REVIEW DASHBOARD OUTCOMES AND PERFORMANCE MEASURES

Domain: ACCESS

- 1) Do these questions get at what you want?
- 2) Does it work for every population?
- 3) Are there items that are less important or redundant?
- 4) Is the burden of collecting the information worth it?
- 5) What might be missing?

The consumer survey will come from consumer themselves. The other one will come from someone else.

The Iowa Participant Experience Survey collects a little of the consumer information.

Measures Collected by [Consumer Survey](#)

- Number 4 and number 9 seem to say the same thing.
- Not really. If you live in Sioux City but have to go to Iowa City for the doctor.
- Range in 6 and 7 needs to be fleshed out a little more.
- It's an access issue. If you need to see someone urgently and you can't; it's not access issue if you only need a physical annually and you can get it within three months.
- But are we really asking about physical care?
- 1-2-3 relevant across all people. Even with general population not sure the relevance of the others.
- Do people get what they need within a reasonable time (without defining reasonable)?
- Need to identify need (annual physical, or mental health crisis appointment), and reasonable time.

- It goes to design; if the interviewer asks what services do you get, or do you need, then the person has the opportunity to go back and be more specific. Can the 1st question be individualized to the respondent?
- Of the 10 questions, three of them relate to medical.
- Some of the regions will be difficult to compare, if you have a doctor that only comes into the region every two weeks.
- Need to define services. Carpet cleaning? Or mental health services such as....
- The surveyor should have a list of the services the individual gets before the interview.
- The waiting list question is good.
- What about multi-occurring? How do we get at that?
- Given your needs have you been provided the specialized services that you might need?
- Access to medical services is limited by location. Accountability is limited to those getting care coordination by those with home health; waiting list needs more information.
- How do we get at the services people want? Do they even have awareness if the service is not available? For example, wellness visit, vocational rehabilitation, etc.

Measures [Collected by Providers](#)

- Some measures are required by the legislation.
- For the question regarding the percent of providers with evening/weekend hours, can we get this another way? How would you get number 18 “staff evidencing fidelity to EBPs”?
- If you get into EBP you need definitions for people. It’s a medical term being applied to a disability system.
- If you ask the provider they’ll all say they’re doing EBPs.
- How did they get referred? Who told you to call the providers? We need to get that info somehow.
- Something like, “It took a lot of effort (or time) to find the service I needed.”
- Questions 15-20 on the provider/system survey could be eliminated. To me these are sub-indicators.
- Save question 17 and question 15.
- When you drove over here how many instruments did you look at? It’s a dashboard.
- But you could have more than one dashboard(s). If you don’t ask essential questions you don’t get the opportunity for continued quality improvement.
- But if you have so many then nothing is important anymore.
- You get some idea of the most powerful indicators and what it tells you about the system.
- Asking the question spurs quality improvement, for example, percent that have evening /weekend hours.
- Question 17: define co-occurring as it’s defined in the legislation.
- Saying you’re co-occurring and being co-occurring are different.

- people who will self-identify as having a substance abuse and mental health issue need to be able to say whether their care was coordinated or not.
- We have a list of questions that are incomplete, pointing in the right direction, and needs work by the experts.
- Missing access to ER/Crisis services.
- Some need to be expanded upon and better identified and we'd have to find a way to implement them.
- I worry about an additional provider burden.
- The survey is very generic and doesn't apply to all providers.
- We'll carry these questions forward to experts to flesh out, and make sure that they are clear, complete and understandable. This is the message that we're giving to the people who will do the work. Much more work needs to be done on these and probably some piloting with each population.

Domain: LIFE IN THE COMMUNITY

Consumer survey

- What does "since receiving services" *mean*? Phrase it differently?
- If we're going to use it across the state, it has to be quantifiable in the end.
- Match with the individual, where they live (in apt, house, with family, etc.). Then look at how they respond to other questions.
- There needs to be a "not applicable" choice. Especially questions that are not relevant in rural areas.

Provider survey

- Question 23: operationalized.
- Question 22: I don't think of a group home as having 15 people. So, ICF-ID is not part of this survey, but what about Resource Centers?
- Careful not to skew findings to where large facilities are.
- How many people are getting HUD housing?

Domain: PERSON CENTEREDNESS

Consumer survey

- Questions 23, 24 and 25: could be "I participated in the development of my service plan."

Provider survey

- Questions 31 and 32: can it be more behavioral than just signing off on it?
- Shared decision making needs to be looked at.
- Does provider have training that addresses cultural diversity, and how do they provide that?

Domain: HEALTH AND WELLNESS

Consumer survey

- Need a general question about health and wellness (see Magellan survey).
- There are questions about smoking cessation, but if there are no funds for it, recommend leaving it off.

- Ask “What are the 2-3 things you’d like to change?” Mine is medications and it’s not even asked about here.
- Primary healthcare: does your primary care doctor listen to you? For example, symptoms blamed on anxiety disorder when you actually do have a physical health issue undiagnosed.
- Exercise, physical activity, what are people doing?
- What will we do with this information? Does it help us?
- Questions 37 and 38 seem nosy. I wouldn’t expect to be asked this. There might be better ways to get to the same information.

Provider survey

- We could use Dr. Turvey’s question and get all other information from IME (for Medicaid eligible).
- Do you support your clients in getting an annual physical?
- Leaning toward micromanaging here a bit. What are we after?
- These would only be asked of people receiving care coordination.
- At a point it starts to sound like a licensing body. Are you doing this, are you not doing it, corrective action plan.
- What about depression or diabetes? Who prioritizes BMI, smoking, drinking/drugs over those things?
- Let’s gather much less information and use much more delimited questions.
- Add a question for all providers, “Have you had training in medication management?”
- Try not to confuse accreditation/licensing standards with this.
- Please add a dental question.

Domain: FAMILY AND NATURAL SUPPORTS

Consumer survey

- Add “I feel lonely.”
- Or add a Likert scale: “I’m happy with the friends I have.”
- Basically “is life good for you?”
- Some are targeted to individual, some to family.
- Too many questions.

Provider survey

- How much time did you spend with someone other than a service provider?
- We need to add in questions that clearly identify individual values (i.e., “I have the level of family support that I want.”).
- Ask “How important is this to you?”
- Don’t take data on face value, data requires analysis. Don’t make a judgment that little family involvement is a bad thing.

Domain: QUALITY OF LIFE AND SAFETY

Consumer survey

- Add the question, “Have you had any involvement with law enforcement in the last year?”

- But what will we do with that data?
- Some regions have a lot more involvement and you can do some crisis intervention training. If you have a brain injury you can have impulse control issues.
- It needs to be asked on both consumer and provider survey.

PUBLIC COMMENT

Comment: Determining priority (MI, ID) versus nonpriority populations (BI, DD) in SF2315, is a good point; are we using equal weight on limited services versus intensive services, as well as core services versus core-plus services? You want the same cross-sections across all regions. In terms of the general length of the survey: a lot of information is captured in the consumer survey so please be considerate of people's time in conjunction with regions and providers doing their own surveys.

Comment: For "Gipper" requirements, there is a baseline intake and six-month follow-up. One measure surveys everyone; another measure only requires a 10 percent sample.

Comment: Jail is not a housing setting. I recommend you track jail separately because if a person is in jail for a period of time they are dis-enrolled from the provider. The outcomes need to evolve with the system. How does the current minimum data interface with this data? I recommend you go narrower in scope at first or implement a sunset date for the initial measures.

Comment: The CHI is not noted and many of these measures are covered in it. Magellan also collects data that is reported for the NOMs. Please re-review the CHI. [Example of CHI](#).

Comment: There's only one safety question and it's very general. Please consider revising.

Next Meeting is Monday, November 5, 2012 from 10:00 am - 3:00 pm at Polk County River Place, 2309 Euclid Ave., Des Moines, IA 50310.

For more information:

Handouts and meeting information for each workgroup will be made available at: <http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>.

Website information will be updated regularly and meeting agendas, minutes, and handouts for the Redesign workgroups will be posted there.